

Opiate Treatment Program (OTP) Guidelines for Pregnant Women (3-7-2017)

TREATMENT APPROACH

Pregnant women who receive care at opioid treatment programs (OTPs) typically present with many needs and are often connected, or need to be connected, with multiple service systems. Taking a team approach to each woman's care and coordinating services with these different systems can improve women's engagement and retention in services. All team members – both OTP staff and other providers who work with pregnant substance users - should use a trauma informed and strength based approach.

PRIORITY ACCESS AND EXPEDITED ENTRY

Women who use opiates and other drugs during pregnancy place their infant at medical risk. When women use opioids throughout their pregnancy, their infants are at high risk to develop symptoms of neonatal abstinence syndrome (NAS). Multiple factors can influence an infant's withdrawal symptoms: which opiates and other substances the mother used during her pregnancy, how frequently she used them; whether she received routine prenatal care and if her use was medically managed can affect the intensity of the infant's symptoms. It is critical that substance using pregnant women receive prenatal and behavioral health care during and following their pregnancy; however, stigma, fear they will lose custody of their infant and the chaotic nature of their addictive lifestyle often makes it difficult to engage and retain these women in treatment. OTPs recognize the importance of quickly engaging pregnant women into services and offering them priority access regardless of their funding source. Because maternal withdrawal may impact the fetus, pregnant women should be able to access medication assisted treatment within 24 to 48 hours of their intake.

FUNDING AND SUPPORT FOR MAT SERVICES

Pregnant women who apply for MAT services but lack funding to support services should be referred to their local department of social services for assistance applying for Medicaid. In Virginia, pregnant women with incomes up to 200% of the Federal Poverty Level qualify for Medicaid support during their pregnancy and up to 60 days postpartum. Depending upon a woman's income, she may qualify for Medicaid funding or be eligible for other financial support from the CSB. Some

CSBs may be able to provide financial support for MAT for pregnant women who are receiving other CSB services.

Virginia's Department of Medical Assistance (DMAS)'s Addiction will implement its Addiction and Recovery Treatment Services (ARTS) program in April 2017 which will offer a more robust continuum of Medically Assisted Treatment services. To qualify for Medicaid reimbursement, Opiate Treatment Programs (OTPs) must be registered Medicaid providers and the individual served must be Medicaid eligible. DMAS has introduced several initiatives to expedite access to and enrollment into medical assistance coverage for pregnant women. These includes allowing hospital presumptive eligibility, removing the requirement for proof of pregnancy, applying a standard for 10-day application processing time for Medicaid eligibility, and expedited enrollment into managed care.

Community Service Board (CSB) Services for Pregnant and Parenting Women

The federal Substance Abuse Treatment and Prevention Block Grant (SAPT BG), which helps fund substance abuse services at Virginia's Community Service Boards (CSBs), requires that its sub recipients, i.e., the CSBs, serve substance using pregnant women within 48 hours of their request for services. If unable to admit a pregnant woman into services within this time frame, the SAPT BG requires that the board provide the woman with the following interim services until they can admit her:

- Counseling and education regarding H.I.V. and T.B.
- Referral to a medical facility, treatment provider or – if appropriate - an emergency room – for prenatal care.
- Advise the woman regarding the potential impact of her substance use on her unborn infant.

In addition, DBHDS directs the CSBs to assess the mother's risk of withdrawal and, if needed, refer her for medical services

OTP Interim Services for Pregnant Women

Due to the potential medical risks to the infant, both CSBs and OTPs should accord treatment priority to pregnant women. If an OTP is unable to admit a pregnant woman within 24-48 hours of her request, they should provide her with the following interim services and document their efforts:

- Offer priority admission if the woman is being transferred from a hospital or another OTP.
- Maintain contact with the woman– by phone or via individual or group meetings - until the OTP is able to admit her into services.
- Confirm that the woman is receiving prenatal care. If she's not enrolled in medical care, she should be referred and linked to a prenatal care provider, emergency room and/or hospital to stabilize the pregnancy.
- Refer the woman to her local CSB or another substance use treatment provider for case management and/or treatment services while she awaits admission to the OTP.
- If other needs are identified, provide appropriate referrals.

OTPs should work collaboratively with local hospitals and OB-GYN providers to share information about each woman's progress in treatment and ensure she is receiving regular prenatal and other necessary medical care. OTPs are encouraged to develop agreements with OB –GYNS, prenatal clinics and hospitals who refer pregnant women to them for MAT services. These agreements should include information and guidance regarding how the OTP will expedite pregnant women's induction into MAT services as well as their policies and procedures related to detoxification following delivery.

INFORMATION SHARING

Women's involvement in multiple service delivery systems impacts on their care. OTPs are familiar with and adhere to the federal confidentiality regulations which protect patient identity. They also recognize the importance of sharing information regarding a client's progress in treatment and the need to obtain informed consent before they can do so. OTP staff should work closely with their pregnant clients to develop trust and obtain consent to share information that impacts on the woman's medical care. OTPs also benefit when other providers share information with them regarding mutual clients. When done properly, information sharing enables OTPs to plan treatment more effectively and advocate for their pregnant clients.

OTPs should have written policies and procedures in place regarding information sharing. These policies and procedures should include the expectation that staff routinely ask pregnant women for permission to exchange information with other medical and behavioral health care service providers involved in their care. OTPs should routinely request pertinent information from other providers as well. If a woman does not provide informed consent, this should be documented in her chart. Staff are strongly encouraged to repeat their efforts at a later date to see if the woman has reconsidered and may be willing to provide consent. OTP staff should document the outcome of all efforts they make.

OTPs are encouraged to develop Memorandums of Understanding with their partners that support the OTP's policies and procedures for serving pregnant women.

These partners include, at a minimum:

- Prenatal Providers (OB-GYNs)
- Birthing Hospitals
- Community Service Boards (Virginia's public providers of substance use and mental health services)
- Other behavioral health providers that offer substance use and/or mental health services e.g. residential treatment facilities, private providers etc.
- Public Health providers
- Local Departments of Social Service/Child Protective Services

Clients' progress, strengths, challenges, and needs should be routinely shared across partners. With appropriate client consent, the OTP shares pertinent information regarding the client's:

- Substance use disorder (S.U.D.) diagnosis and treatment plan, including referrals to non-MAT substance use treatment services
- Changes or adjustments in MAT dosage
- Participation and progress in treatment
- Toxicology test results
- Individualized plan for delivery and infant's care

- Understanding regarding the infant’s potential for neonatal abstinence syndrome (NAS), how NAS is treated and any concerns she may have shared.

(Do we want to define what information OTPs need to obtain from pre-natal care providers and expectations for gathering info?)

Regular updates from other service delivery systems regarding a client’s’ progress can aid the OTPs’ treatment planning efforts. Treatment partners can also benefit from information shared by the OTPs and be better able to support the OTP’s efforts to retain clients in care.

OTP Perinatal Navigator

Communication between systems is easiest and most effective when programs have clear policies and expectations in place regarding the sharing of information. OTPs are strongly encouraged to identify at least one medical staff member to serve as the central point of contact for providers who need medical information regarding the OTP’s pregnant and postpartum clients.

When women on MAT have a pain management need or present for delivery, their medical providers need to obtain information regarding their dose and participation in treatment. In order to appropriately plan for a mother’s and baby’s care, hospital discharge staff also need information prior to the mother’s release. For example, they will need to know if the mother is eligible and able to return for MAT services, the likelihood she may be detoxed after delivery, and if so, how and when she will be detoxed. If CPS and CSB staff become involved in her care, they will need similar information.

PLANS OF SAFE CARE

Background

The federal Child Abuse Prevention and Treatment Act (CAPTA), was issued in 2003, reauthorized in 2010 and most recently revised in 2016. CAPTA requires that states ensure that health-care providers involved in the delivery or care of substance exposed infants *notify child protective services*, and develop a *plan of safe care* for these infants.” CAPTA’s intent is to identify infants who may be at risk for abuse or neglect as a result of prenatal exposure and make sure that

states provide needed services to both the mother and her infant to ensure the well-being of the mother, the infant and their family.

Congress passed the Plans of Safe Care Improvement Act in May 2016 to provide additional guidance to states regarding Plans of Safe Care and how states should monitor them. The 2016 revision included two important changes: 1) the expectation that a plan be developed for any infant affected by in utero substance exposure to any controlled substance— not just illegal ones and 2) that services be identified for both the child and their family. Congress did not specify what services need to be included in a Plan of Safe Care, which provider needs to develop the plan, nor how states should monitor them. Instead they left it up to the individual states to create and implement a plan for responding to the problem of perinatal substance use. Virginia recently updated its substance exposed newborn reporting law (Code of Virginia §63.2-1509) to comply with CAPTA, and is working with the National Center for Substance Abuse and Child Welfare to develop guidelines for creating Plans of Safe Care. As of July 1, 2017, providers will be expected to develop a Plan of Safe Care for any infant that is experiencing withdrawal or was exposed in utero to a controlled substance.

What Is A Plan of Safe Care?

A Plan of Safe Care identifies the services and supports substance exposed infants and their mothers need to ensure the child's optimal health and development. Ideally the plan should begin during the mother's pregnancy, address the mother's and- if involved - her partner's mental health and substance use disorder treatment needs as well as their needs for medical, social services, and parenting services. The plan should be individualized and address the child's medical and developmental needs as well as strategies to ensure the mother – and others involved in the child's care- have the necessary skills and supports to meet the child's needs

A Plan of Safe Care should be multidisciplinary and include input from the different service delivery systems – including OTPs - involved in treating the mother and her newborn. Which provider initiates the Plan and/or maintains it, will vary depending upon the mother's pathway into care, her treatment needs and those of her newborn as well as the family's preferences for care. Women on MAT who are stable in their Recovery when they become pregnant are likely to

have very different needs than pregnant women who have an opiate use disorder and are not engaged in treatment or have other difficulties.

The Plan of Safe Care should be initiated by the first provider who identifies the woman's substance use. This might be her prenatal, OTP, CSB or home visiting provider or the hospital where she delivers. Depending on the woman's situation and treatment needs, this provider may develop and manage her Plan or may refer her to another provider better suited to monitor and meet her treatment needs. For example, if the mother is stable in her recovery, the pregnancy is planned and no difficulties are noted, the OTP and prenatal provider may be the only providers involved in her care. More often, however, the child and/or family members may have significant case management or service needs and require additional services from the CSB and/or CPS. When multiple providers are involved, they need to work together to determine who will oversee the plan.

Unless CPS is providing prevention services, they do not become involved until the baby is born. If CPS does get involved, it is likely that they –in conjunction with the OTP and, if involved, the CSB–will be responsible for overseeing the Plan of Safe Care. However, if CPS withdraws from the case, responsibility for the plan will shift to either the OTP or CSB – whichever serves as the primary treatment provider.

What is the OTPs Role Developing Plans of Safe Care?

Although OTP's do not provide service for newborns, they do serve women throughout pregnancy and beyond and can play a critical role ensuring a child's safety. OTP staffs have almost daily contact with their clients and may be able to recognize and identify concerns more quickly than other providers. They are the "experts" when it comes to providing guidance regarding the woman's medication needs and expectations for MAT services. If a pregnant woman receives concurrent services from a CSB, the OTP and CSB will need to work together on her Plan of Safe Care. Once the baby is born CPS may provide additional services; if so they will participate and may direct the plan of safe care. If the OTP is the woman's sole provider of services, the OTP will be responsible for helping her prepare for her delivery, plan how she will care for her new born and resolve other service needs that may impact on the infant. This level of case management may be new to many OTPs. If an OTP is unable to provide intensive

case management services to a pregnant woman, they are strongly encouraged to refer her to a CSB, or a home visiting program for these services

CSBs are the single point of entry in Virginia for publicly provided services for substance use and mental health disorders for adults and children. They are also home to many of Virginia's Part C Early Intervention programs that address developmental delays in children 0 to 3. CSBs are unique in that they provide substance use treatment and support services to women during and following pregnancy as well as developmental and mental health services for their children. Because they offer a range of services across the life span, it is anticipated that CSBs will assume the lead on many Plans of Safe Care.

Prenatal and MAT providers are encouraged to refer pregnant substance using women to their local CSB as early in their pregnancy as possible. With input from the OTP and prenatal providers, the CSB will create an individualized Plan of Safe Care and initiate services. If a woman and her newborn are identified at the time of delivery or postpartum, the hospital, medical provider, and/ or child welfare provider should refer her to the CSB to develop and implement a Plan of Safe Care. Together, the CSB and other service providers involved in the mother and infant's care should identify and develop strategies to address the family's needs. If the family refuses or fails to follow through with their referral to the CSB or another case management provider, the OTP will be responsible for developing and managing the mother and child's Plan of Safe Care.

OTP's are encouraged to collaborate with their partners to ensure that they exchange information on a regular basis. OTPs can better plan for their client's care when they are able to obtain the following information from their partners:

- Infant's hospital delivery summary. (The summary should address the infant's risk for NAS, whether discharged on medication for withdrawal, necessary follow up, etc.)
- Mother's discharge summary from the hospital.
- Any drug tests that may have been done on mom during her hospitalization.
- The mother's attendance and participation in prenatal care.

- Any prescriptions for pain medication given to the mother during her pregnancy and/or at discharge.
- Any efforts made to address family planning with the mother.
- If child welfare is involved, their plans for the newborn.
- Whether a Plan of Safe Care:
 - i. Has been initiated by the OTP and, if so, what is included in the plan e.g. will mother be maintained or detoxed following delivery? What supports are in place to ensure optimal care for the infant? Etc.
 - ii. Has another provider initiated the Plan of Safe Care? If so, what recommendations did the OTP offer and what role will they play?

RECOGNIZING AND REPORTING CHILD MALTREATMENT

OTPs' medical and social work staffs are mandated child abuse and neglect reporters. Staff should be alert to signs of suspected child abuse and/or neglect and know how to report suspected maltreatment. OTPs should have written policies and procedures that outline how staffs are expected to report and respond to suspected situations of child abuse and or neglect.

Virginia's Department of Child Protective Services provides guidance and training for mandated reports on their website <https://www.dss.virginia.gov/abuse/mr.cgi>

COORDINATED CARE AND CASE MANAGEMENT

OTPs recognize the importance of providing coordinated care and case management services when serving pregnant women with substance use disorders. Pregnant women who receive MAT services may need case management services to address concerns such as housing, general medical and dental needs, financial assistance, provisions for the newborn etc. OTP staff can provide the coordinated care and/or case management services themselves or refer women to a CSB or home visiting program to receive them

Starting in April, 2017, Medicaid approved OTP providers will be able to request reimbursement for care coordination services they provide to Medicaid eligible clients. OTPs will need to determine if the services they provide meet the woman's needs and DMAS's expectations. If not, the OTP may need to enhance

their services or else refer women to another treatment provider who can provide the case management services she needs.

Pregnant MAT clients who are stable in their recovery may not require intensive case management services. In such cases, the care coordination provided by the OTP may be sufficient to meet their needs. However, many pregnant women who have a substance use disorder have multiple social, emotional, family and legal problems and are likely to require a more intensive level of services than that typically provided through care coordination. OTPs should assess each woman's needs and interest in receiving wrap around services. This will help them determine if they are able to address her needs or need to refer her elsewhere for case management services.

All efforts to refer pregnant women or provide them with case management services should be documented in the client's record. OTP staff should use a "warm handoff"¹ to link pregnant and post-partum women to services and follow up to ensure the woman is engaged in care. Staff should ensure that the necessary consents have been signed and information about the woman's progress in care shared between partners on a regular basis. If a woman refuses or fails to follow through with a referral for case management or other services, OTP staff should document this in her chart and include their follow up efforts. If women do not follow through with a referral for case management services, the OTP will be expected to assume responsibility for developing her Plan of Safe Care, coordinating services with her medical provider and ensuring that her case management needs are met. OTPs are encouraged to also offer written information regarding women's treatment and services and make them available where women may easily access them.

Community Service Boards (CSB)

Virginia's CSBs provide public services for adults and children who have or are "at risk" for a mental illness, substance use disorder or developmental disabilities. The continuum of available services varies by CSB. Local OTPs are encouraged to work closely with their CSBs to develop Memorandums of Understanding to

¹ "warm handoff" - a supported referral in which a service provider offers assistance engaging the woman in care.

support continued collaboration and facilitate referrals for their clients and their client's children

The federal Substance Abuse Prevention and Treatment Block Grant (SAPT BG), which funds public substance abuse services, requires that its sub recipients i.e., CSBs, provide services for pregnant and parenting substance using women and their children. As previously noted, the SAPT BG requires that CSBs admit pregnant substance using women within 48 hours of the woman's request. If unable to do so, the CSB must provide "interim services" to the woman, and contact the Department of Behavioral Health and Developmental Service (DBHDS) for assistance developing an alternative plan of care. Virginia's CSBs are required to provide 1) gender specific substance abuse services for pregnant and parenting women 2) therapeutic services for their children, 3) medical care coordination for mothers and their children as well as 4) sufficient transportation and 5) child care so that women can participate in treatment.

As previously noted, OTPs can refer pregnant women to their local CSB for ongoing services and supports. The CSB can assess and arrange for residential treatment for those women who need a more intensive level of care. They may also be able to support or arrange for funding for MAT services. By maintaining regular communication, the OTP and CSB can work together to ensure that the woman's needs are identified and appropriate services provided.

To learn which CSB serves your client, go to:

<http://www.dbhds.virginia.gov/individuals-and-families/community-services-boards>

Coordinated Care with Other Behavioral Health Providers

Pregnant women who receive MAT services should be provided with mental health services as needed, either on-site or via a "warm hand-off" i.e. a supported referral that involves assistance engaging her in care. When women receive mental health or substance use disorder services off-site from another provider, the OTP ensures that consents are signed and information about the woman's progress in treatment is shared between partners.

The OTP offers onsite substance use treatment services that meet the American Society of Addiction Medicine outpatient standards and which utilize an evidenced based and trauma informed approach.

OTPs must provide, at minimum, individual or group substance use counseling to women once every two weeks for at least one hour. If the OTP does not offer ASAM level I.0² (outpatient) or level 2.1³ (intensive outpatient that is less than 9 hours per week) substance use treatment services, they may elect to refer pregnant women to an accredited substance use disorder provider for additional substance use treatment services. OTPs are strongly encouraged to provide support groups for women who are parenting and/or pregnant if they have adequate census to support such a service.

For OTPs that do not offer ASAM level I.0 or level 2.1 treatment, or for those clients who need residential or inpatient services, the OTP will work closely with their partnering substance use treatment agency to ensure that mutual clients receive appropriate care. Clients should be assessed by the partnering agency for concurrent opiate and other substance use disorders and receive evidenced based, trauma informed substance use treatment services. The OTP will work closely with their partner substance use treatment agency and share:

- Client progress and challenges
- Client participation
- Dosage change information
- Toxicology test results

Coordinated Care with Home Visiting Programs

All families need support to function at their best. When traditional supports aren't available or sufficient, home-visiting services may be available to assist them. Home visiting is a proven family strengthening strategy in which trained professionals bring services to families' homes during their child's first three to five years. Virginia has a variety of home visiting programs throughout the Commonwealth which are voluntary and free of charge. Home visiting services are available to families in need of additional support; however, certain programs have special requirements based on the child's age or service needs and not all programs operate in all areas.

² The ASAM Criteria: Treatment Criteria for Addictive, Substance Related and Co-occurring Conditions, American Society of Addiction Medicine, Third Edition, 2013

³ Ibid.

- *Project LINK* operates at nine CSBs and provides intensive case management and home visiting to substance using pregnant and parenting women.
- *Healthy Families* is a nationally recognized program available to families which is designed to promote positive parenting, improve child health, promote responsive parent-child interaction, and prevent child abuse and neglect.
- *CHIP of Virginia*, focuses on increasing access to health care for low-income children and their families. CHIP targets children from birth to age six, when comprehensive prevention-oriented services make the greatest impact in the life of a young child.
- *Part C Early Intervention* provides services to children birth to age 3 who have a developmental delay or disability.

For more information about these and other home visiting programs and their criteria for admission go to: <http://homevisitingva.com/programs.php>

To locate programs in your area, check out:

<http://homevisitingva.com/vamap.php>

Coordinated Care with Medical and Prenatal Providers:

To ensure clear and timely communication with women's medical providers, each OTP should designate at least one medical staff member to be responsible for communicating with prenatal care providers and birthing hospitals.

If a pregnant woman who is receiving MAT services is not already receiving prenatal care, she should be referred to a prenatal care provider who has experience working with women with substance use disorders. Substance using women may be fearful or ashamed to follow through with medical care and may need additional support to do so. Providing the woman with a "warm handoff" to ensure linkage, helps ensure that the woman will follow through with the medical referral. The OTP should maintain contact with the pre-natal provider throughout the woman's pregnancy and maintain consents so they may continue to exchange relevant information about the woman's progress in treatment and her medical condition. The OTP should be prepared to share information with the OB/GYN regarding the woman's treatment progress including: dosage level & changes,

treatment participation and challenges, her toxicology test results and any plans for detoxification.

When a woman on MAT presents in labor, the hospital must contact the OTP to learn if she is currently enrolled in services and what her dose is. The hospital must also be able to confirm her participation in treatment.

Code of Virginia §63.2-1509 was revised in 2017 to comply with CAPTA changes and the Plan of Safe Care Improvement Act. As of July 1, 2017, all health care providers must file a report with DSS within 6 weeks of an infants' birth if they determine that the infant was affected in utero by the mother's use of a controlled substance or is experiencing withdrawal. Health care providers must also file a report with CPS if, within 4 years of the child's birth, the child has an illness, disease or condition attributable to the mother's use of a controlled substance during her pregnancy or the child evidences signs of a fetal alcohol spectrum disorder. Unless an investigation is required or necessary to protect the child's safety, CPS must perform a family assessment and develop a plan of safe care for the child - regardless of whether the local department makes a finding of abuse or neglect.

Previously women on prescribed methadone were exempt from report to CPS unless their infants tested positive for the use of another controlled substance not prescribed for them. They also were not referred by the hospital to the CSB as mandated by 32.1-127.⁴ Because of the changes to 63.2-1509, infants whose mothers are on prescribed MAT will be reported to CPS so that a family assessment can be conducted. Hospitals will also be required to refer them to their local CSB for services.

(Include information regarding how new legislation will impact on clients)

Coordinated Care for Substance Exposed Infants

Giving birth and assuming care for a newborn is a joyful event but can be overwhelming and fraught with challenges even for the best prepared. OTPs should help women anticipate their needs and develop an individualized Delivery

⁴ **Code of Virginia § 32.1-127** requires hospitals to have protocols requiring written discharge plans for substance using postpartum women and their infants and requires the CSB to manage the discharge plan.

Plan. OTP staff may assist the woman or refer her to another service provider e.g. CSB, home visiting program, hospital social worker who can help her plan and make necessary arrangements. The woman's Delivery Plan should address details such as: who will transport and pick her up from the hospital; what personal items and information she needs to bring to the hospital for herself and her newborn e.g. insurance information, car seat, layette, etc.; where the baby will sleep, what baby supplies she will need when she returns home; whether she will continue MAT following delivery and, if not, how will she care for her infant while being detoxed etc.

Pregnant women should be educated about the importance of having a medical home for themselves and their children and how to find them. They also need to be educated about the importance of informing their child's medical providers about their child's substance exposure. As substance exposed infants' age, they may display effects from their in utero exposure. To ensure substance exposed children receive appropriate medical and development follow up, medical providers need to know about their in utero exposure. Mothers should be counseled about the importance of sharing this information and may need support and encouragement in order to do so.

Any child may experience a developmental delay; however, opiate exposed newborns may be at increased risk. With appropriate early intervention, however, these children do quite well. Mothers should be informed about the availability of Part C Early Intervention services and how to access them if their child displays signs of a developmental delay. OTPs' may elect to provide referrals to medical homes and early interventions services themselves or refer women to another provider, such as a CSB or home visiting program, to do so.

To learn more about the Infant and Toddler Connection (Virginia's Early Intervention Part C services for children birth to three) go to: <http://infantva.org/>

Coordinated Care with Family Service Providers

Pregnant women – even those with older children - who receive MAT services, should be referred, through a warm handoff, to home visiting services and parenting supports. Pregnant women – even those with older children - should be offered education regarding parenting. Women who have had previous pregnancies may not have cared for or had difficulty caring for their older children

and may benefit from support and guidance. Mothers should be educated regarding the importance of bonding with their newborn, the potential effects MAT can have on their infant e.g., irritability, difficulty with self soothing etc., what neonatal abstinence syndrome (NAS) is and how it is treated, techniques they can use to help soothe infants who are experiencing withdrawal and the importance of developing supports for themselves. Evidenced based parenting programs designed for parents with substance use disorders are available. OTPs may seek to provide these services themselves or refer mothers through a warm hand-off, to a parenting program off-site. When women are referred to off-site programs, the OTP should encourage women to sign consents and follow up to be sure information about the woman's progress is shared between partners.

OTP staff should be prepared to work with the mother's home visitor or other case manager to advocate for child care services when they are needed

Coordinating Care with the Child Welfare System

Virginia Code: §63.2-1509: Virginia Law regarding the Reporting of Substance Exposed Infants to Child Protective Services:

OTP staff should be routinely trained on the requirements of Virginia Code §63.2-1509 which requires that infants be reported to the local child protective services department if the reporter has reason to suspect that the child is abused or neglected.

OTP staff should understand the implications of this law and educate their pregnant clients regarding the law and how it may affect them. Staff should routinely address pregnant women's concerns about a potential referral to child welfare and provide guidance in a strength based and compassionate manner.

If a pregnant or parenting client is involved in the child welfare system, the OTP will work with child protective services as needed to comply with court orders and safety plans. The OTP will ensure that the appropriate consents are signed and information about the woman's progress in treatment is shared with child welfare. OTP staff will ensure that pregnant women on MAT understand the potential implications of delivering a child exposed to MAT including the infant's potential for NAS or referral to child welfare.

OTP staff understand that child welfare involvement can be highly stressful for parents, but realize that it is likely that reunification is that parent's most important goal for treatment. With this in mind, OTP staff are transparent with parents about the child welfare process, implications of continued use or relapse and the strengths of their case.

Mandated Reporting of Child Abuse and/or Neglect

The OTP understands the importance of routinely educating staff members on their role as mandated reporters of child abuse and neglect. Staff members understand their responsibilities as reporters and how to file a report. OTP staff members work collaboratively with their local child welfare offices. The OTP has designated a treatment liaison for their local child welfare office.

When working with mothers who are involved with child welfare, OTP staff routinely share the following information when they have appropriate consent:

- Mother's progress in treatment including strengths, challenges and relapses.
- Mother's dose changes.
- Mother's toxicology test results and any treatment plan changes due to positive tests.
- Any safety concerns about the children.

The OTP has written policies and procedures to screen for and respond to child safety concerns for newborns and older children in the home. The policies outline staff responses including how to work with child welfare when they have safety concerns.

Coordinated Care with Criminal Justice Systems

If pregnant women who receive MAT services are engaged in the criminal justice system, the OTP will work with the Department of Justice, probation services, or other partners as needed to comply with court orders. The OTP will ensure that consents are signed and information about the woman's progress is shared with criminal justice and legal partners.

STAFF TRAINING & EDUCATION:

The OTP understand the importance of regular staff training on topics specific to pregnant women with substance use disorders. Training can be provided through a variety of mediums e.g., face to face, webinars etc. Areas of training should include:

- The effects and causes of Neonatal Abstinence Syndrome.
- The effects of opiates and other substances of abuse on the infant.
- The benefits and criteria for breastfeeding with substance exposed infants when breast feeding is not contraindicated.
- The benefits of breastfeeding with infants who are experiencing Neonatal Abstinence Syndrome (NAS).
- The benefits of non-pharmacological approaches to treating Neonatal Abstinence Syndrome (NAS) including breastfeeding, skin to skin contact, and rooming in.
- Soothing techniques for infants experiencing withdrawal symptoms.
- The symptoms and treatment of postpartum depression.
- Safe Sleep practices.
- How babies communicate.

CLIENT EDUCATION AND PREPARATION

Neonatal Abstinence Syndrome:

The OTP understands the importance of educating and supporting pregnant women on how to prepare for the potential of Neonatal Abstinence Syndrome and how to support their infants following delivery. OTP staff will work with each mother to:

- Develop a Delivery Plan which includes preparing for the potential of NAS.
- Understand how smoking may influence the incidence of NAS and SIDS and discuss options for going smoke free.
- Understand what her child may experience if they develop NAS and how NAS is treated.

- Understand the risks of drinking while pregnant and how drinking can lead to the development of a Fetal Alcohol Spectrum Disorder (FASD).
- Understand the benefits of breastfeeding, particularly for infants with NAS, and help mothers prepare for how they will feed their infant.
- Understand the benefits of non-pharmacological approaches in treating NAS, including rooming in and skin-to-skin contact. OTP staff will encourage mothers to speak with their birthing hospitals to understand the role of non-pharmacological approaches in the treatment of NAS.
- Understand the importance of bonding and attachment to infant development and how mothers' can enhance their relationship with their newborn
- Learn about early intervention services and how to access them if they suspect their child may be experiencing a developmental delay

MAT Dosage and Birth Planning:

OTP medical staff will work with pregnant women to prepare for potential changes with MAT during pregnancy and after delivery by:

- Educating mothers how pregnancy can impact on their MAT needs and the possibility that they may require dosage changes throughout their pregnancy - including the potential of split dosing.
- Preparing mothers for the likelihood that their methadone dose will need to be decreased following delivery. Mothers should also be educated on safe sleep practices, including the dangers on co-sleeping while taking MAT.
- Developing a pain management plan for the postpartum period which addresses the potential of relapse
- Educating mothers regarding safe sleeping practices, including the dangers of co-sleeping with their baby.
- Developing a plan for the ongoing use of MAT post-delivery
- If mother is unable or unwilling to continue MAT, develop a thoughtful detox plan with her which includes:
 - Up to a 30-day detoxification plan.

- Connection to ongoing substance use treatment support.
- Connection to other support services to help mother maintain her recovery.
- A plan for attending sober support groups.
- A relapse prevention plan.

Postnatal Planning:

OTP staff work with pregnant women to prepare for their return home with their infant, including:

- Educating mothers regarding infant withdrawal, what to anticipate and how to deal with the emotions and reactions they may experience.
- Educating mothers about the potential of postpartum depression, what to anticipate, warning signs for depression and where and when to seek care.
- OTP staff use the Edinburgh Depression Scale to regularly screen pregnant women and new mothers for postpartum depression.
- Educating mothers on safe sleep practices for their infant, including the dangers of co-sleeping while taking MAT or using other drugs or alcohol.